		FOR OHF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0018143

Facility Name: Fair Havens Christian Home

Address: 1790 South Fairview Avenue (Number) Decatur (City) 62521 (Zip Code)

County: Macon

Telephone Number: 217-429-2551 **Fax #** ( )

IDPA ID Number: 23-7437316001

Date of Initial License for Current Owners: 1975

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501c3			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: William O. Buskirk **Telephone Number:** 217-525-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from July 1, 2002 to June 30, 2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Mark Havrilka
(Title) Chief Financial Officer

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) William O. Buskirk, CPA
(Firm Name & Address) Eck, Schafer & Punke LLP, 600 East Adams Springfield, IL 62701-1624
(Telephone) 217-525-1111 Fax # 217-525-1120

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	161	Skilled (SNF)	161	58,765	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	161	TOTALS	161	58,765	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	19,660	13,244	7,806	40,710	8
9	SNF/PED					9
10	ICF	8,889	5,943		14,832	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,549	19,187	7,806	55,542	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.52%

D. How many bed-hold days during this year were paid by Public Aid?
474 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 12/12/1975

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 161 and days of care provided 7,806

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 06/30/2003 Fiscal Year: 06/30/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Fair Havens Christian Home # 0018143 **Report Period Beginning:** July 1, 2002 **Ending:** June 30, 2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	250,556	34,375	13,498	298,429		298,429		298,429			1
2	Food Purchase		311,086		311,086		311,086	(4,585)	306,501			2
3	Housekeeping	263,193	53,622		316,815		316,815		316,815			3
4	Laundry											4
5	Heat and Other Utilities			148,280	148,280		148,280	(5,807)	142,473			5
6	Maintenance	67,874	29,244	47,801	144,919		144,919	11,327	156,246			6
7	Other (specify):*											7
8	**TOTAL General Services**	581,623	428,327	209,579	1,219,529		1,219,529	935	1,220,464			8
	B. Health Care and Programs											
9	Medical Director			14,000	14,000		14,000		14,000			9
10	Nursing and Medical Records	2,082,703	184,126	5,638	2,272,467		2,272,467		2,272,467			10
10a	Therapy			384,893	384,893		384,893		384,893			10a
11	Activities	29,364		8,925	38,289		38,289		38,289			11
12	Social Services	128,166	7,724		135,890		135,890		135,890			12
13	Nurse Aide Training											13
14	Program Transportation		1,649		1,649		1,649		1,649			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,240,233	193,499	413,456	2,847,188		2,847,188		2,847,188			16
	C. General Administration											
17	Administrative	90,451	3,427	274,476	368,354		368,354	(211,083)	157,271			17
18	Directors Fees											18
19	Professional Services			10,438	10,438		10,438	9,686	20,124			19
20	Dues, Fees, Subscriptions & Promotions			29,315	29,315		29,315	(10,624)	18,691			20
21	Clerical & General Office Expenses	106,174	22,626	155,191	283,991		283,991	(8,171)	275,820			21
22	Employee Benefits & Payroll Taxes			531,275	531,275		531,275	26,923	558,198			22
23	Inservice Training & Education											23
24	Travel and Seminar			14,466	14,466		14,466	9,176	23,642			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			124,523	124,523		124,523	4,045	128,568			26
27	Other (specify):*											27
28	**TOTAL General Administration**	196,625	26,053	1,139,684	1,362,362		1,362,362	(180,048)	1,182,314			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,018,481	647,879	1,762,719	5,429,079		5,429,079	(179,113)	5,249,966			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Fair Havens Christian Home #0018143 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			204,097	204,097	(195)	203,902	39,669	243,571			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			24,166	24,166		24,166	(17,204)	6,962			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* **Financing Fee**			444	444		444		444			36
37	**TOTAL Ownership**			228,707	228,707	(195)	228,512	22,465	250,977			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			20,442	20,442		20,442		20,442			39
40	Barber and Beauty Shops	23,147	1,161		24,308		24,308		24,308			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			88,148	88,148		88,148		88,148			42
43	Other (specify):* **Apt./Cong.**			422,382	422,382	195	422,577		422,577			43
44	**TOTAL Special Cost Centers**	23,147	1,161	530,972	555,280	195	555,475		555,475			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,041,628	649,040	2,522,398	6,213,066		6,213,066	(156,648)	6,056,418			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,585)	2		4
5	Telephone, TV & Radio in Resident Rooms	(9,588)	5		5
6	Rented Facility Space	(3,000)	5		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	22,842	30		9
10	Interest and Other Investment Income	(56,523)	32		10
11	Discounts, Allowances, Rebates & Refunds	(2,267)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(99,948)	21		24
25	Fund Raising, Advertising and Promotional	(66)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached	28,205			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (124,930)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(31,718)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (31,718)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (156,648)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Fair Havens Christian Home

ID# 0018143

Report Period Beginning: July 1, 2002

Ending: June 30, 2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Machine Income	$ (532)	17	1
2	Net Activity (income) expense	2	17	2
3	Equipment Disposal Loss	243	17	3
4	Increase in Cash Value Life	(269)	17	4
5	Marketing	(10,558)	20	5
6	Exempt interest income on restricted investments	39,319	32	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	28,205		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,585)	0	0	0	0	0	0	0	0	0	0	(4,585)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(12,588)	6,781	0	0	0	0	0	0	0	0	0	(5,807)	5
6	Maintenance	0	11,327	0	0	0	0	0	0	0	0	0	11,327	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(17,173)	18,108	0	0	0	0	0	0	0	0	0	935	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(556)	(210,527)	0	0	0	0	0	0	0	0	0	(211,083)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	9,686	0	0	0	0	0	0	0	0	0	9,686	19
20	Fees, Subscriptions & Promotions	(10,624)	0	0	0	0	0	0	0	0	0	0	(10,624)	20
21	Clerical & General Office Expenses	(102,215)	94,044	0	0	0	0	0	0	0	0	0	(8,171)	21
22	Employee Benefits & Payroll Taxes	0	26,923	0	0	0	0	0	0	0	0	0	26,923	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	9,176	0	0	0	0	0	0	0	0	0	9,176	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	4,045	0	0	0	0	0	0	0	0	0	4,045	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(113,395)	(66,653)	0	0	0	0	0	0	0	0	0	(180,048)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(130,568)	(48,545)	0	0	0	0	0	0	0	0	0	(179,113)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Fair Havens Christian Home **#** 0018143 **Report Period Beginning:** July 1, 2002 **Ending:** June 30, 2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	22,842	16,827	0	0	0	0	0	0	0	0	0	39,669	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(17,204)	0	0	0	0	0	0	0	0	0	0	(17,204)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	5,638	16,827	0	0	0	0	0	0	0	0	0	22,465	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(124,930)	(31,718)	0	0	0	0	0	0	0	0	0	(156,648)	45

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached schedule						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Christian Homes Inc	100.00%	$ 6,781	$ 6,781	1
2	V	6	Maintenance				11,327	11,327	2
3	V	17	Administrative	274,476			63,949	(210,527)	3
4	V	18	Directors						4
5	V	19	Professional Services				9,686	9,686	5
6	V	20	Fees, Subscriptions						6
7	V	21	Clerical				94,044	94,044	7
8	V	22	Employee Benefits				26,923	26,923	8
9	V	23	Inservice Training						9
10	V	24	Travel & Seminar				9,176	9,176	10
11	V	26	Insurance				4,045	4,045	11
12	V	30	Depreciation				16,827	16,827	12
13	V								13
14	Total			$ 274,476			$ 242,758	$ * (31,718)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	This workpaper is not applicable.								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2002 Ending: ne 30, 2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		This workpaper is not applicable.				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	1993-A GR Bond	x		Debt Restructure	$3,110.63	01/01/93	$ 420,000	$ 342,195	01/01/18	0.0650	$ 24,166	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$3,110.63		$ 420,000	$ 342,195			$ 24,166	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 420,000	$ 342,195			$ 24,166	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	N/A	2
3. Under or (over) accrual (line 2 minus line 1).	$	#VALUE!	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	#VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1998	8
	1999	9
	2000	10
	2001	11
	2002	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fair Havens Christian Home COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0018143

CONTACT PERSON REGARDING THIS REPORT Brenda Lavin

TELEPHONE 217-732-9651 FAX #: 217-732-8686

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-12-21-428-011	21-16-2 Mueller's 3rd RSVY	$ 339.76	$
2.	07-07-15-451-006	Hickory Point Christian Village Lot 1	$ 2,889.24	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 3,229.00	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 56,500 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	57,000	1972	$ 54,638	1
2	Home Office Allocation			9,101	2
3	TOTALS	57,000		$ 63,739	3

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	155		1977	1977	$ 2,180,767	$ 51,312	40	$ 54,519	$ 3,207	$ 1,402,930	4
5					384,841		20	19,242	19,242		5
6	6		1983	1983	109,815	2,745	35	3,138	393	53,528	6
7											7
8	Home Office Allocation				65,639	1,887		1,887		33,899	8
	Improvement Type**										
9	Wall Guards			1979	485		15			485	9
10	Garage			1979	4,167	139	30	139		3,405	10
11	Heat Tapes			1980	2,151		15			2,151	11
12	Heating System			1981	14,100		10			14,100	12
13	Wall Coverings			1981	1,277		10			1,277	13
14	Heating Control System			1982	20,503		20			20,503	14
15	Fence Guard Rail			1982	2,027		10			2,027	15
16	Electric Work			1982	2,133		10			2,133	16
17	Fire Alarm			1982	858	12	20	12		858	17
18	New Office			1983	2,700	90	30	90		1,845	18
19	Wallcovering			1983	2,301		10			2,301	19
20	Tiling			1983	615		10			615	20
21	Office Remodel			1984	2,594	86	30	86		1,670	21
22	Window Installation			1984	2,083		10			2,083	22
23	Down Spouts			1984	639		10			639	23
24	Floor Covering			1984	550		10			550	24
25	Roof Work			1984	163,201	4,080	40	4,080		83,043	25
26	Electric Door			1984	10,229		10			10,229	26
27	Floor Covering			1985	3,457		10			3,457	27
28	Fire Alarm			1985	1,705	85	20	85		1,566	28
29	Windows			1985	3,558		10			3,558	29
30	Roof			1985	29,843		15			29,843	30
31	Door Kick Guards			1985	419		10			419	31
32	Electrical Recepticals			1986	2,419	121	20	121		2,077	32
33	Wiring			1987	7,530	376	20	376		6,171	33
34	Ceiling			1987	300		10			300	34
35	Rewiring			1987	1,600	80	20	80		1,253	35
36	Wallpapering			1989	505		5			505	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Signs	1989	$ 1,224	$	5	$	$	$ 1,224	37
38	Soap Dispensers	1989	672		5			672	38
39	Compressor Freezer	1989	810		5			810	39
40	Storage Cabinet	1990	1,100	73	15	73		979	40
41	Tempering Valve	1990	3,199	213	15	213		2,840	41
42	Remodel Dining Room	1991	4,708	235	20	235		3,055	42
43	Install Panic Bars	1991	780		10			780	43
44	Install Window	1991	988	66	15	66		809	44
45	Flooring	1991	4,380		5			4,380	45
46	Roof Repair	1991	29,860	1,991	15	1,991		24,224	46
47	A/C Compressor	1991	1,076		5			1,076	47
48	Touchpads Exit Door	1991	792		10			792	48
49	Stainless Steel Sink	1991	1,630		10			1,630	49
50	Walkway Canopy	1991	4,412	221	20	221		2,597	50
51	Showers	1991	3,669		10			3,669	51
52	Remodel Office	1992	8,715	436	20	436		4,832	52
53	Door Locks & Magnets	1992	2,540	42	10	42		2,540	53
54	Interior Landscaping	1992	3,839	159	10	159		3,839	54
55	Handrails	1993	12,800	853	15	853		8,957	55
56	Wall Cabinets	1993	2,564	171	15	171		1,767	56
57	Bathroom Remodel	1993	12,341	617	20	617		6,273	57
58	Nurses Station Desks	1994	18,588	929	20	929		8,748	58
59	Alarm/Auto Door	1994	4,257	426	10	426		3,940	59
60	Cabinets	1994	1,480	99	15	99		899	60
61	Carpeting in Office	1993	979		5			979	61
62	Gas Rooftop Piping	1994	4,905	245	20	245		2,144	62
63	Heating & A/C Unit	1994	5,565	278	20	278		2,433	63
64	Remodel Garage	1995	3,704	370	10	370		3,114	64
65	Remodel Nurses Station	1995	15,656	1,566	10	1,566		12,789	65
66	Thru Wall A/C Unit	1995	3,120	325	8	325		3,120	66
67	Flourescent Light Covers	1995	1,218		5			1,218	67
68	Roof Work	1995	52,000	3,467	15	3,467		28,025	68
69	Service Sink	1995	1,003	100	10	100		817	69
70	TOTAL (lines 4 thru 69)		$ 3,239,585	$ 73,895		$ 96,737	$ 22,842	$ 1,835,391	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,239,585	$ 73,895		$ 96,737	$ 22,842	$ 1,835,391	1
2	Wallcovering Dayroom Station 1	1995	2,573		5			2,573	2
3	Baseboard Pipe	1995	2,978		5			2,978	3
4	Thru Wall A/C	1995	3,120	390	8	390		3,055	4
5	Shower Valves	1995	1,807	181	10	181		1,403	5
6	Resident Room Signs	1995	1,516		5			1,516	6
7	Utility Room Cabinet	1995	599	40	15	40		310	7
8	Magnets for Fire Doors	1995	795		5			795	8
9	Fire Door Closers	1995	1,200		5			1,200	9
10	Install 2 Deck Faucets	1995	826		5			826	10
11	Nurse Call System - *	1995	925	62	10	62		682	11
12	Install Sprinkler Laundry	1995	557	56	10	56		429	12
13	Electronic Thermostats	1995	733		5			733	13
14	Breakers 6/receptacles	1995	883		5			883	14
15	Remodel Main Lobby	1995	4,569		5			4,569	15
16	Remodel Station	1996	12,472		5			12,472	16
17	Rooftop Heating/AC Dining Room	1996	11,975	1,198	10	1,198		8,985	17
18	Floorwork Dayroom	1996	2,247		5			2,247	18
19	Heating & A/C Station	1996	7,550	755	10	755		5,600	19
20	Floorwork Dining Room	1996	6,974	697	10	697		5,169	20
21	Water Softener	1996	10,580	1,058	10	1,058		7,582	21
22	Blank								22
23	2 Sprinkler Cooler	1996	772		5			772	23
24	Remodel Station	1996	8,261		5			8,261	24
25	Shelving Linen Closet	1997	540		5			540	25
26	Gas Piping in Laundry	1997	1,155	116	10	116		725	26
27	Heating & A/C Rooftop	1997	8,950	895	10	895		5,519	27
28	Floorwork Station 4 Hall	1997	10,153	1,015	10	1,015		6,175	28
29	Dining Room Announcement	1997	549		5			549	29
30	Remodel Beauty Shop	1997	1,370		5			1,370	30
31	Energy Management System	1997	14,637	732	20	732		4,148	31
32	Remove Slab Freezer Area	1997	2,860		3			2,860	32
33	Floor Tile - Station 4 Rooms	1998	7,500	1,000	5	1,000		7,500	33
34	TOTAL (lines 1 thru 33)		$ 3,371,211	$ 82,090		$ 104,932	$ 22,842	$ 1,937,817	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,371,211	$ 82,090		$ 104,932	$ 22,842	$ 1,937,817	1
2	Station 3 Carrier FR A/C	1998	7,597	760	10	760		3,863	2
3	Carpet Chapel/Lobby/Office	1998	2,483	456	5	456		2,483	3
4	Wood Cove BS/60 Rooms	1998	9,412	1,727	5	1,727		9,412	4
5	Alarm System	1998	11,937	1,194	10	1,194		6,064	5
6	Wallpaper Station 1 & 2 Rooms	1998	38,443	7,073	5	7,073		38,443	6
7	Ventilation - Electric Room	1999	1,875	375	5	375		1,781	7
8	48-Safety Grab Bars	1999	864	173	5	173		807	8
9	161-Glass/Resident Walls	1999	2,256	226	10	226		1,055	9
10	Install Grab Bars	1999	2,401	240	10	240		1,080	10
11	Install 24V Door Closer	1999	1,189	238	5	238		1,071	11
12	Water Heater - Station 3	1999	655	131	5	131		557	12
13	Remodel Station 4	1999	26,585	1,772	15	1,772		7,523	13
14	Back Door Alarm Pad	1999	2,874	287	10	287		1,220	14
15	Nurse Call Units	1999	598	60	10	60		250	15
16	Front Countertop	1999	881	59	15	59		246	16
17	Mixing Valve/Install	1999	524	105	5	105		429	17
18	Pella Storm Window - 13	1999	527	105	5	105		429	18
19	Smoke Detectors-4	1999	553	55	10	55		225	19
20	Carrier Rooftop Unit	1999	6,779	678	10	678		2,768	20
21	Wallpaper Station 3 Rooms	1999	23,706	4,741	5	4,741		19,348	21
22	Compressors (3)	2000	2,239	63	3	63		2,239	22
23	Cove Base-Station 3	2000	1,408	282	5	282		1,081	23
24	Baseboard	2000	1,371	274	5	274		1,028	24
25	Light Fixtures (2 Day Room)	2000	947	95	10	95		356	25
26	Floor Tile-Hall/Bath/Kitchen	2000	3,079	616	5	616		2,259	26
27	Panic	2000	1,059	212	5	212		724	27
28	Security Locks-Front Door	2000	900	180	5	180		585	28
29	Exhaust Fans (6)	2000	702	140	5	140		455	29
30	Carrier Rooftop Unit	2000	7,637	764	10	764		2,419	30
31	Ceiling Grid Covers	2000	1,418	177	8	177		546	31
32	Compressor Room 101	2000	1,131	75	15	75		231	32
33	REMODELING FHCH	2000	6,395	640	10	640		1,867	33
34	TOTAL (lines 1 thru 33)		$ 3,541,636	$ 106,063		$ 128,905	$ 22,842	$ 2,050,661	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,541,636	$ 106,063		$ 128,905	$ 22,842	$ 2,050,661	1
2	REMODELING PROJECT	2000	7,075	708	10	708		1,829	2
3	(2) BOILERS INSTALLED W/ EMERG LIGHTS	2001	20,942	2,094	10	2,094		4,363	3
4	Roof Top A/C Unit	7/2/2001	1,295	130	10	130		260	4
5	(2) BOILERS INSTALLED W/ EMERG LIGHTS	7/15/2001	782	78	10	78		156	5
6	Compressor - Dining Room A/C	10/6/2001	646	215	3	215		376	6
7	Replace (8) Fire Alarm-A/C Relays	4/17/2002	1,519	506	3	506		633	7
8	Heating & Cooling System - Office	6/14/2002	2,275	228	10	228		247	8
9	Locks (3) for Fire Doors	6/15/2002	4,077	408	10	408		442	9
10	2-Compressors-Station One Day Room	7/12/2002	1,128	376	3	376		376	10
11	Tile Work-Kitchen, Mechanical Room & 7D	8/14/2002	5,580	256	20	256		256	11
12	Water Cooler-Station #1	9/6/2002	715	119	5	119		119	12
13	(22) Carrier through the wall A/C units	9/1/2002	28,380	2,957	8	2,957		2,957	13
14	Floor Covering/Cove Base - 11 Baths	9/18/2002	3,960	660	5	660		660	14
15	(2) Exit doors & Installation	11/21/2002	2,718	91	20	91		91	15
16	Reroof Garage	1/8/2003	1,665	139	6	139		139	16
17	(36) Bathroom Grab Bars-Stats	1/19/2003	7,677	384	10	384		384	17
18	Install New Circuit for Food Well	3/22/2003	511	34	5	34		34	18
19	Install New Locks on all doors	5/1/2003	2,550	43	10	43		43	19
20	Fire Alarm Door Closure/Holder	6/24/2003	895	8	10	8		8	20
21	Roof Top A/C Unit	6/30/2003	5,090	42	10	42		42	21
22	Fully depreciated land improvements	10/21/1985	69,530		20			69,530	22
23	Sidewalk, landscaping, fence etc.	6/10/1992	24,404	1,221	20	1,221		16,734	23
24	Entrance sidewalk replacement	6/28/2001	7,850	786	10	786		5,542	24
25	Concrete work	5/30/2003	4,230	58	10	58		58	25
26	Storage shed	4/4/2000	1,495	150	10	150		488	26
27	New Liquid O2 Building	6/2/2003	1,995	17	10	17		17	27
28									28
29									29
30									30
31	* Less: Disposal		(925)					(682)	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,749,695	$ 117,771		$ 140,613	$ 22,842	$ 2,155,763	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 577,730	$ 82,994	$ 82,994	$	Various	$ 365,101	71
72	Current Year Purchases	59,735	5,024	5,024		Various	5,024	72
73	Fully Depreciated Assets	468,806				Various	468,806	73
74	Home Office Allocation	113,917	12,061	12,061			63,069	74
75	TOTALS	$ 1,220,188	$ 100,079	$ 100,079	$		$ 902,000	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1986 Wayne Bus	1987	$ 30,743	$	$	$	8	$ 30,743	76
77	Patient Transportation	Van	1988	3,317				3	3,317	77
78										78
79	Home Office Allocation			13,125	2,879	2,879			6,023	79
80	TOTALS			$ 47,185	$ 2,879	$ 2,879	$		$ 40,083	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,080,807	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 220,729	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 243,571	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 22,842	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,097,846	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Land	$ 359,816	$	$	86
87	Duplex/Equipment	6,756,957	204,943	1,345,679	87
88	Forysth Land Dev. & Assist Living	360,204			88
89	Other Equip/Buildings	11,494	195	4,182	89
90	Land Improvements	648,004	38,154	330,456	90
91	TOTALS	$ 8,136,475	$ 243,292	$ 1,680,317	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: This workpaper is not applicable.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	This	hrs							2
3	Licensed Recreational Therapist	workpaper	hrs							3
4	Licensed Physical Therapist	is not	hrs							4
5	Physician Care	applicable.	visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of June 30, 2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 526,442	$	1
2	Cash-Patient Deposits	23,833		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 112,691)	1,365,622		3
4	Supply Inventory (priced at FIFO)	34,013		4
5	Short-Term Investments	249,839		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Acc Int Rec/Other A/R	16,395		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,216,143	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	414,454		13
14	Buildings, at Historical Cost	754,018		14
15	Leasehold Improvements, at Historical Cost	10,046,617		15
16	Equipment, at Historical Cost	1,440,194		16
17	Accumulated Depreciation (book methods)	(4,583,308)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	883,362		21
22	Other Long-Term Assets (spe CIP	360,204		22
23	Other(specify): Other Assets	5,336		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 9,320,877	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 11,537,020	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 178,634	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,833		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	298,860		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,615		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 502,942	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	342,195		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred apartment income	1,097,851		43
44	Apt & congr life right & security dep	3,810,480		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,250,526	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,753,468	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,783,552	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 11,537,020	$	48

***(See instructions.)**

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,625,175	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,625,175	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,098,377	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,098,377	17
	B. Transfers (Itemize):		
18	**Transfer out to affiliate**	(940,000)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (940,000)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 5,783,552	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,105,424	1
2	Discounts and Allowances for all Levels	(1,033,985)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,071,439	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	622,872	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 622,872	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	33,264	13
14	Non-Patient Meals	4,585	14
15	Telephone, Television and Radio	1,200	15
16	Rental of Facility Space	3,000	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	17,786	19
20	Radiology and X-Ray	21,240	20
21	Other Medical Services	3,068	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 84,143	23
	D. Non-Operating Revenue		
24	Contributions	32,794	24
25	Interest and Other Investment Income***	56,523	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 89,317	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Unrealized G(L) on Sale of Equipment/Investments	255	28
28a	Residential/Congregate	443,417	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 443,672	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,311,443	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,219,529	31
32	Health Care	2,847,188	32
33	General Administration	1,362,362	33
	B. Capital Expense		
34	Ownership	228,707	34
	C. Ancillary Expense		
35	Special Cost Centers	467,132	35
36	Provider Participation Fee	88,148	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,213,066	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,098,377	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,098,377	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,636	1,804	$ 42,412	$ 23.51	1
2	Assistant Director of Nursing	1,843	2,024	45,654	22.56	2
3	Registered Nurses	9,841	10,786	294,221	27.28	3
4	Licensed Practical Nurses	26,176	27,452	424,190	15.45	4
5	Nurse Aides & Orderlies	112,647	117,611	1,238,527	10.53	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,538	3,692	37,699	10.21	8
9	Activity Director	2,325	2,438	29,364	12.04	9
10	Activity Assistants					10
11	Social Service Workers	10,632	11,112	128,166	11.53	11
12	Dietician					12
13	Food Service Supervisor	1,622	1,817	19,710	10.85	13
14	Head Cook					14
15	Cook Helpers/Assistants	23,861	25,828	230,846	8.94	15
16	Dishwashers					16
17	Maintenance Workers	4,035	4,238	67,874	16.02	17
18	Housekeepers	26,604	27,991	263,193	9.40	18
19	Laundry					19
20	Administrator	2,974	2,997	90,451	30.18	20
21	Assistant Administrator					21
22	Other Administrative	404	463	10,318	22.29	22
23	Office Manager	1,767	1,980	38,381	19.38	23
24	Clerical	4,267	4,586	57,475	12.53	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Beauty Shop	2,166	2,211	23,147	10.47	33
34	TOTAL (lines 1 - 33)	236,338	249,030	$ 3,041,628 *	$ 12.21	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	310	$ 13,498	1.3	35
36	Medical Director	48	14,000	9.3	36
37	Medical Records Consultant	96	1,210	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	1,240	10.3	39
40	Physical Therapy Consultant	3,940	241,631	10A.3	40
41	Occupational Therapy Consultant	2,353	139,609	10A.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	36	2,233	10A.3	43
44	Activity Consultant	109	8,407	11.3	44
45	Social Service Consultant				45
46	Other(specify) UR Committee		1,420	10A.3	46
47	Dental Consultant	10	500	10.3	47
48					48
49	TOTAL (lines 35 - 48)	6,998	$ 423,748		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Blair Wagner	Administrator	0	$ 45,249
Nancy Jones	Administrator	0	45,202
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 90,451

B. Administrative - Other

Description	Amount
Management Expense	$ 274,476
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 274,476

C. Professional Services

Vendor/Payee	Type	Amount
Van Ostrand	Legal	$ 1,011
Davis & Campbell	Legal	6,730
The Finn Group	Management Assessment	300
	Architectural Fees/CIP	2,397
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 10,438

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 91,860
Unemployment Compensation Insurance	23,724
FICA Taxes	225,192
Employee Health Insurance	168,375
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Expense	16,326
Employee Physicals	5,735
Employee Uniforms	63
Home Office Allocation	26,923
TOTAL (agree to Schedule V, line 22, col.8)	$ 558,198

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,439
Health Care Worker Background Check (Indicate # of checks performed)	
Software Support & Fees	3,976
Life Services Fees	8,281
Internet & Remote Fees	261
Subscriptions	1,726
Miscellaneous Dues & Fees	853
Licenses & Fees	155
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,691

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	5,436
Miscellaneous	225
Seminar Expense	8,805
Home Office Allocation	9,176
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 23,642

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	This workpaper is not applicable.		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2002 Ending: June 30, 200

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network - $8,281**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **13,138** Line **3.10.2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **88,148**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **4,585**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **0**
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Eck, Schafer & Punke LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **It will be provided upon completion.**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Fair Havens Christian Home
Allocation on Benefits 6/30/2003 kdb 11/4/2005

Payroll Tax	Unemploy Contrib	Worker's Comp	Health Ins	Benefit Percentage	Employee Expense	Employee Uniforms	Employee Physicals	
153,796.91	16,260.00	62,964.00	119,625.00					
18,739.91	2,316.00	8,940.00	14,625.00	6,261.14				
20,617.98	2,400.00	9,300.00	10,125.00	10,243.90				572,786.34
5,032.33	372.00	1,416.00	4,500.00	4,659.82				
10,775.65	1,272.00	4,944.00	8,625.00	6,325.32				
14,504.84	912.00	3,552.00	10,875.00	13,120.13	16,324.77	62.72	5,735.00	
1,724.58	192.00	744.00		902.34				
225,192.20	23,724.00	91,860.00	168,375.00	41,512.65	16,324.77	62.72	5,735.00	572,786.34

Less Benefits:		41,512.65
	Line 3.22.3	531,273.69

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